

The following information must be included with your complaint:

- **Name, address and telephone number of person filing the complaint**
- **Name of the insurance company**
- **Name of person insured**
- **Policy number and claim number (if applicable)**
- **Agent or adjuster's name**
- **Date of occurrence**
- **A brief description of why the complaint is being filed. Attach copies of documents that will help with the investigation.**

Once we receive your correspondence, it will be assigned to an investigator who will review it and take the necessary steps to resolve this matter.

Our job is to serve the citizens of Arkansas and assist them with their insurance questions or problems. We appreciate your interest.

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION
TO THE ARKANSAS INSURANCE DEPARTMENT**

I, _____ authorize _____
(name of consumer) (name of insurer or other party)

to disclose the following health information to the employees of the Arkansas Insurance Department upon request:

(specific and meaningful description of the information to be provided)

This authorization is valid for 24 months from the date of signature, unless revoked. If I wish to revoke this authorization, I can do so by sending a written request to the Arkansas Insurance Department.

I understand that I have the right to revoke this authorization in writing, unless _____
has already taken action under the authorization. (name of covered entity)

Certain information received by the Arkansas Insurance Department may be subject to disclosure by the Department and will not be protected by federal law. The Arkansas Insurance Department will not disclose your health information except as allowed by law.

Signature of consumer (or personal representative of consumer, along with description of the representative's authority)

Date